



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHARLES W KENNEDY JR MD
601 TEXAN TRAIL SUITE 201
CORPUS CHRISTI TX 78411

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-14-0977-01

MFDR Date Received

November 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On March 1, 2008 the Texas Medical Fee Schedule changed. Please be advised that this was a **DESIGNATED DOCTOR EXAMINATION FOR MMI & IR. PER THE DWCFORM 32 ACCEPTED CONDITIONS WERE 1. CONCUSSION, 2. CERVICAL THORACIC AND LUMBER SPINE, 3. LEFT WRIST AND 4. LEFT KNEE.**"

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable to be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011 (d). The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 03, 2013	CPT Code 99456-W5-WP	\$150.00	\$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 Texas Register 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 02, 2013

- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

Explanation of benefits dated November 07, 2013

- W1 - WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456-W5-WP with five units in the amount of \$1,100.00 for a Maximum Medical Improvement (MMI) and Impairment Rating (IR) examination.

Per 28 Administrative Code §134.204 states the following: (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include.

(3) The following applies for billing and reimbursement of an MMI evaluation, (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.

(4) The following applies for billing and reimbursement of an IR evaluation, (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas, (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet), (ii) The MAR for musculoskeletal body areas shall be as follows, (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used, (II) If full physical evaluation, with range of motion, is performed, (-a-) \$300 for the first musculoskeletal body area; and (-b-) \$150 for each additional musculoskeletal body area and (iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR and for non musculoskeletal body areas the following states: (D) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR, (i) Non-musculoskeletal body areas are defined as follows, (I) body systems; (II) body structures (including skin); and, (III) mental and behavioral disorders , (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.

Review of the submitted documentation DWC-32 (Request for Designated Doctor Examination) and DWC-69 (Report of Medical Evaluation) support that a request for designated doctor exam was requested to address the following issues of Maximum Medical Improvement (MMI) and Impairment Rating (IR) examination. Documentation supports Impairment Rating reviewed three musculoskeletal body areas using Range of Motion (ROM) method to the upper extremity (wrist), lower extremity (knee) area and Diagnosis Related Estimate (DRE) method to the spine (cervical, thoracic and lumbar) body area. One non musculoskeletal body area was reviewed.

Therefore, the total allowable Mar for CPT Code is \$1,100.00.

2. The respondent issued payment in the amount of \$950.00. Based upon the documentation submitted, additional reimbursement in the amount of \$150.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

1/29/14
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.